



CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF MEDICAL LICENSURE AND DISCIPLINE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

APPLICATION FOR PHYSICIAN ASSISTANT LICENSE INSTRUCTION SHEET

Please read all instructions carefully before completing and submitting your application. Failing to follow instructions may delay your licensure. All auxiliary forms you need are included in this packet.

If your application is not complete within six months of filing, it may be considered abandoned and discarded.

Physician Assistant Prescriptive Authority

This application includes a section to concurrently apply for Prescriptive Authority. Prescriptive Authority enables you to prescribe medication under the supervision of a licensed physician in Delaware.

- If you do not wish to apply concurrently for Prescriptive Authority, you may apply later. To apply later, use the [Physician Assistant Application for Prescriptive Authority](#).
- **The application for Physician Assistant licensure is NOT an application for a controlled substance registration (CSR).** For the CSR application and instructions, see [Application for Controlled Substances Registration – Physician's Assistants](#).
- If you apply for your Physician Assistant license and CSR at the same time, the CSR application will be processed *after* your prescriptive authority is approved. When your Delaware CSR is approved, you must then file for a [federal DEA registration](#) for Delaware.

Checklist for All Applications

The following requirements apply to all applications regardless of whether you are applying by Examination, Reciprocity/Endorsement or Reapplication.

- ☐ Submit completed, signed and notarized [Application for Physician Assistant License](#).
 - Make sure all questions are answered unless the instructions tell you to skip a question.
 - Read the AFFIDAVIT section.
 - Sign the application in front of a notary public.
- ☐ Enclose [processing fee](#) by check or money order made payable to "State of Delaware."
- ☐ Complete the *Criminal History Record Check Authorization* form to request state and federal criminal background checks. Follow the instructions on the authorization form to arrange to be fingerprinted.
 - You must meet this requirement *even if* you recently had a criminal background check done for some other reason.
- ☐ If you now hold, or have ever held, a PA license in any jurisdiction other than Delaware, arrange for the Board office to receive a *Verification of Physician Assistant License* form from *each* jurisdiction where you have held a license.
 - Before forwarding the form, check whether the jurisdiction requires a fee.
 - The Board office must receive the completed verification *directly* from the other jurisdiction. The jurisdiction's seal must be affixed to the form.
 - Internet verifications or faxed verifications will not be accepted.
- ☐ Request a self-query from the National Practitioner and Healthcare Integrity and Protection Data Banks (NPDB/HIPDB) website at www.npdb-hipdb.hrsa.gov. The self-query report will be mailed to your address. When you receive the report, mail (do not fax) the **original report** to the Board office.

- ☐ If you answer “yes” to any questions in the DISCLOSURES section, you must submit a separate signed statement to fully explain your answer.
- ☐ If you have never been issued a U.S. Social Security Number (SSN), submit a [Request for Exemption from Social Security Number Requirement](#).
 - *The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants:* Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 Del. C. §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 Del. C. §2216) and for other lawful purposes.

Additional Requirements for Applications by Examination

The following requirements apply when you are filing your initial application for PA licensure on the basis of the Physician Assistant National Certifying Examination (PANCE).

- ☐ Submit an 8" X 11 1/2" copy of your Physician Assistant diploma.
- ☐ Arrange for the Board office to receive a *Verification of Physician's Assistant Education* form from the PA program from which you graduated.
 - The program from which you graduated must be AMA-approved.
 - The Board office must receive the completed form *directly* from the school. The school's seal must be affixed to the form. If no seal is available, the form must be notarized.
 - Internet verifications or faxed verifications will not be accepted.
- ☐ Submit an 8" X 11 1/2" copy of your National Commission on Certification of Physician Assistants (NCCPA) Certificate.
 - If you are applying by Examination but are not yet nationally certified, you do not need to submit this copy.
- ☐ Arrange for the Board office to receive an official *Verification of Certification* from [NCCPA](#), sent directly to the Board office.

Additional Requirement for Applications by Endorsement/Reciprocity and Reapplications

The following requirement pertains only when

- you are applying on the basis of endorsement/reciprocity (current PA licensure in another state or jurisdiction) or reapplying for Delaware PA licensure that lapsed
 - your CME within the past two years is current.
- ☐ Submit proof of 100 hours of continuing medical education (CME).
 - The CME must consist of 40 hours of AMA Category I CME (Section 25.2 of the Board's Rules and Regulations).

Temporary Licensure

The temporary permit allows you to practice until you have passed the PANCE and your permanent license is issued. You may be granted a temporary license if you

- have graduated from an accredited PA program and otherwise meet ***all*** the requirements for licensure except for passing the PANCE, and
- have registered to take the next available PANCE.

The temporary license remains valid until the examination results are available. If you fail the PANCE, the temporary license immediately becomes null and void and you must cease practicing as a PA.

To apply for a temporary permit...

- ☐ Answer “yes” to Question 2 on the application form.
- ☐ Enclose the [temporary license fee](#) by check or money order made payable to “State of Delaware.”
 - This fee is *in addition to* the processing fee for your application. However, you may combine the fees in one check or money order.



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APPLICATION FOR PHYSICIAN ASSISTANT LICENSE

TYPE OF APPLICATION

1. Select the type of application you are filing (check one):

- ☐ Examination – I have *never* been licensed in *any* state or U.S. territory and am applying on the basis of the Physician Assistant National Certifying Examination.
- ☐ Endorsement/Reciprocity – I hold a *current, active* PA license in another state or U.S. territory.
- ☐ Reapplication – I held a Delaware PA license that has lapsed. My license number was: **C5** - _____

2. Are you also applying for a temporary license because you have not yet taken and passed the examination?
Yes ☐ No ☐

3. Are you also applying for Prescriptive Authority? Yes ☐ No ☐ If yes, check one:

- ☐ Non-Controlled Substances *Only* ☐ *Both* Controlled *and* Non-Controlled Substances

The application for prescriptive authority is NOT an application for a controlled substance registration (CSR). For the CSR application and instructions, see [Application for Controlled Substances Registration – Physician's Assistants](#).

IDENTIFYING AND CONTACT INFORMATION

4. Full Name: _____
Last First Middle

5. Other Names Used: _____

6. Date of Birth (month/day/year): _____ Gender: Male ☐ Female ☐

7. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐
• If yes, enter your SSN: _____
• If no, you must file a [Request for Exemption from Social Security Number Requirement](#).

8. Mailing Address: _____

City State Zip

9. Phone: _____ Email: _____
Home Work

EDUCATION, EXAMINATIONS AND CERTIFICATION – All applicants complete this section.

10. Are you a graduate of an AMA-approved PA program? Yes ☐ No ☐ If yes, enter this information:

Institution Name: _____ Graduation Date: _____

Address: _____
Street City State Zip

Submit an 8" X 11 1/2" copy of your Physician Assistant diploma and arrange for the Board office to receive a Verification of Physician's Assistant Education form from the PA program, sent *directly* from the school(s).

11. Have you ever been deemed ineligible to sit for a PA national certifying examination for any reason?

Yes ☐ No ☐ If yes, explain: _____

12. Are you certified as a PA by the National Commission on Certification of Physician Assistants (NCCPA)?

Yes ☐ No ☐ If yes, enter the following information about your certification and *skip to the CME section*:

Certification Number: _____ Date of Certification: _____

13. Have you taken the national certifying examination? Yes ☐ No ☐

- If yes, enter the date you sat for the exam: _____
- If no, enter the date of the exam for which you have registered: _____

CONTINUING MEDICAL EDUCATION – Complete this section *only if* you are applying by Endorsement/Reciprocity or by Reapplication.

14. Do you currently log continuing medical education (CME) with a nationally recognized agency? Yes ☐ No ☐ If yes, check agency:

☐ NCCPA

☐ AAPA

☐ Other – Enter agency: _____

15. Within the past two years, have you completed at least 100 hours of CME, 40 of which are Category I CME?

Yes ☐ No ☐ **If yes, submit proof of your current CME.**

LICENSURE HISTORY – All applicants complete this section.

16. Have you ever been denied a license or a registration to practice as a PA? Yes ☐ No ☐ If yes, explain:

17. Have you ever held a PA license in any jurisdiction other than Delaware? Yes ☐ No ☐ If yes, list *each* jurisdiction where you now hold, or have *ever* held, a PA license.

JURISDICTION	LICENSE NUMBER	EXPIRATION DATE

Arrange for the Board office to receive a Verification of Physician Assistant License form from each jurisdiction where you have held a license.

DISCLOSURES – All applicants complete this section. If you answer “yes” to any question in this section, submit a signed statement fully explaining your answer. The statement should specify where and when the incident occurred, issues involved and any further information you wish to provide.

18. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense in any jurisdiction, including any offense for which you have received a pardon? Yes ☐ No ☐

Arrange for the Board office to receive state and federal criminal background checks.

19. Have you ever been disciplined or had formal written action taken by a hospital staff or medical society, or licensing board of another jurisdiction? Yes ☐ No ☐

Request a self-query from the National Practitioner and Healthcare Integrity and Protection Data Bank (NPDB/HIPDB) and, when you receive the report, mail the *original* to the Board office.

20. Have you ever been the subject of an investigation by a licensing authority, medical association, hospital or other healthcare institution? Yes ☐ No ☐ If yes, provide a copy of any documents in your possession related to the final disposition of the investigation and continue to Question 21. If no, skip to Question 22.
21. Do you agree to sign an authorization for the Board of Medical Licensure and Discipline and the Division of Professional Regulation to obtain any and all information concerning the disposition of the investigation directly from the licensing authority, medical association, hospital or other healthcare institution? Yes ☐ No ☐
22. Within the past two years, have you had a physical or mental disability which could reasonably be thought to interfere with your practice as a physician assistant, including use or abuse of dangerous or addicting substances? Yes ☐ No ☐
23. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? Yes ☐ No ☐
24. Within the past two years, have you engaged in the illegal use of controlled dangerous substances? Yes ☐ No ☐
25. Are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? Yes ☐ No ☐

DUTY TO REPORT

26. To obtain a license in Delaware, you must certify that you understand that you have a **mandatory** obligation to file a written report with the Board of Medical Licensure and Discipline within 30 days if you have any reason to believe that a medical practitioner *other than yourself* is (or may be) guilty of unprofessional conduct as defined in 24 Del. C. §1731 OR that he/she is (or may be):
- medically incompetent
 - mentally or physically unable to engage safely in the practice of medicine
 - excessively using or abusing drugs including alcohol.

I certify that I have read and understand the provisions of [24 Del. C. §1730, 24 Del. C. §1731 and 24 Del. C. §1731A](#) and that I understand my *duty to report*. Yes ☐ No ☐

27. To obtain a license in Delaware, you must certify that you understand that you have a **mandatory** obligation to make an immediate oral report to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

I certify that I have read and understand [16 Del. C. §903](#) and that I understand my *duty to report*. Yes ☐ No ☐

28. To obtain a license in Delaware, you must certify that you understand that you have a **mandatory** obligation to self report all of the following:
- Any change in hospital allied healthcare privileges and any disciplinary action taken by any medical society against you within 30 days (24 Del. C. §1730(b)(1))
 - Any civil or criminal investigation in any jurisdiction which concerns your certification or license or other authorization to practice medicine within 30 days (24 Del. C. §1730(b)(2))
 - All information concerning medical malpractice claims settled or adjudicated to final judgment, as provided in Chapter 68 of Title 18, within 60 days. (24 Del. C. §1730 (c))
 - Each final judgment, settlement, or award against you regardless whether you have malpractice insurance, within 30 days of the final judgment, settlement, or award. (24 Del. C. §1731A (f))
 - Any reports filed against you with the Department of Services for Children, Youth and Their Families under Chapter 9 of Title 16 concerning child abuse or neglect (24 Del. C. §1730 (d))
 - Any reports filed against you to the Division of Long Term Care Residents Protection under Chapter 85 of Title 11 concerning adult abuse, neglect, mistreatment or financial exploitation (24 Del. C. §1730 (d))

I certify that I have read and understand all of provisions in the [Delaware Medical Practice Act](#), including those listed above, and understand my *duty to self report*. Yes ☐ No ☐

PRESCRIPTIVE AUTHORITY – Complete this section *only if* you answered “Yes” to Question 3 (applying for prescriptive authority).

29. Enter the names of **all** physicians who will supervise you, regardless of business/practice or location:

Arrange for **each** supervising physician you listed above to submit a **Statement of Supervising Physician** (see next page). Enclose all statements with the application.

STATEMENT OF SUPERVISING PHYSICIAN

1. Name of Supervising Physician: _____
2. Delaware Physician License Number: **C** ____ - _____ 3. Specialty: _____
4. DEA Numbers : _____
Federal Delaware
5. Which controlled substance schedules are you authorized to prescribe? ☐ II ☐ III ☐ IV ☐ V
6. **Which controlled substance schedules is the Physician Assistant applicant authorized to prescribe under your supervision?** ☐ II ☐ III ☐ IV ☐ V
7. Are you delegating authority to the Physician Assistant applicant to request and issue professional samples of controlled legend medications? Yes ☐ No ☐ **If yes, as the supervising physician, you remain ultimately responsible for prescribing, dispensing and storing the controlled substances even though you are delegating authority to the PA.**
8. **As the supervising physician, I understand that I may not at any given time supervise more than two physician assistants, unless a regulation of the Board increases or decreases the number (24 Del C. §1771(e)).** Yes ☐ No ☐
9. How many Physician Assistants do you currently supervise? _____
10. I understand that I must promptly submit a new *Application for Prescriptive Authority* to notify the Board of Medical Licensure and Discipline of any change in supervising physician(s) or schedule(s) authorized.
Yes ☐ No ☐

Signature of Supervising Physician: _____ **Date:** _____

You may copy this page.

STATEMENT OF SUPERVISING PHYSICIAN

1. Name of Supervising Physician: _____
2. Delaware Physician License Number: **C** ____ - _____ 3. Specialty: _____
4. DEA Numbers : _____
Federal Delaware
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10. I understand that I must promptly submit a new *Application for Prescriptive Authority* to notify the Board of Medical Licensure and Discipline of any change in supervising physician(s) or schedule(s) authorized.
Yes ☐ No ☐

Signature of Supervising Physician: _____ **Date:** _____

STATEMENT OF SUPERVISING PHYSICIAN

1. Name of Supervising Physician: _____
2. Delaware Physician License Number: **C** ____ - _____ 3. Specialty: _____
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Federal Delaware
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10. I understand that I must promptly submit a new *Application for Prescriptive Authority* to notify the Board of Medical Licensure and Discipline of any change in supervising physician(s) or schedule(s) authorized.
Yes ☐ No ☐

Signature of Supervising Physician: _____ **Date:** _____

30. I understand that I must promptly submit a new *Application for Prescriptive Authority* to notify the Board of Medical Licensure and Discipline of any change in supervising physician(s) or schedule(s) authorized. Yes ☐ No ☐

To assure consideration of your license application at the next Board meeting, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:

- **Completed, signed and notarized application form**
- **Fee payment**
- **All required supporting documentation.**

Applications that are not complete within six months of filing may be considered abandoned and discarded.

Please note: When your application is complete, please allow 4-8 weeks to receive your permanent Physician Assistant license.

AFFIDAVIT

I swear all of the following:

- I am the person who executed this application.
- The statements contained on this application are true in every respect.
- I have not suppressed or withheld information that might affect this application.
- I will abide by the laws and the ethical standards of this profession.
- I have read and understand this statement.

I hereby authorize and consent to have an investigation conducted to determine my professional qualifications, to determine whether I have previously engaged in unprofessional conduct as defined in 24 *Del. C.* §1731 or the Rules and Regulations of the Delaware Board of Medical Licensure and Discipline and to determine that I am physically and mentally capable of engaging in the practice of medicine with safety to the public.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal or foreign), court, association, institution or other organization having control of any documents, records or other information pertaining to me, to furnish to the Delaware Board of Medical Licensure and Discipline any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or other pertinent data and to permit the Delaware Board of Medical Licensure and Discipline or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application, subsequent licensure or practice thereunder.

I understand and acknowledge that the Delaware Board of Medical Licensure and Discipline will rely on the information I have provided in this application in making its determination on licensure. I hereby expressly agree to

- Keep the information in this application current until such time as the Board has finally acted on it, and
- Promptly provide any and all additional information requested by or on behalf of the Board.

Signature of Applicant: _____ **Date:** _____

City of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____, 2____.

Signature of Notary: _____

SEAL

My Commission Expires: _____

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.

Instructions for Requesting a Criminal Background Check

Both state and federal criminal background checks are required.

Locations

Kent County – Primary Facility

State Bureau of Identification
Blue Hen Mall & Corporate Center
655 Bay Rd. Suite 1B
Dover, DE 19901

Walk-ins accepted: Mon 9 am – 7 pm, Tue - Fri 9 am – 3 pm
Customer Service: (302) 739-2134

New Castle County - Satellite Facility

State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(Between Rts. 72 and 896 on Rt. 40)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility

Delaware State Police Troop Four
South DuPont Hwy & Shortley Rd. Georgetown DE
19947
(Across from DelDOT & the State Service Ctr.)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants Residing in Delaware

1. If you are using the New Castle or Sussex Counties locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.
2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of \$69.00, to cover both the State and Federal criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. *Personal checks are not accepted in any county.* As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

Out-of-State Applicants

1. You can be fingerprinted by your local police agency. All types of fingerprint cards are accepted. If your local police agency cannot provide a fingerprint card, call **(302) 739-2134** to request a fingerprint card.
2. Your *Authorization for Release of Information* form and fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, sex, etc.), your form will be returned. Send the *Authorization* form, fingerprint card, and certified check or money order (*personal checks are not accepted*) for \$69.00 made payable to "Delaware State Police" to:

**Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430**

⇒ **ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.**

DO NOT SEND THE FORM OR FEE TO THE BOARD OFFICE



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AUTHORIZATION FOR RELEASE OF INFORMATION

CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

PLEASE PRINT OR TYPE ALL INFORMATION IN BLACK INK.

CHECK TYPE OF LICENSURE FOR WHICH APPLYING:

- | | |
|--|---|
| <input type="checkbox"/> Adult Entertainment | <input type="checkbox"/> Nursing |
| <input type="checkbox"/> Deadly Weapons Dealer | <input type="checkbox"/> Nursing Home Administrator |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Medical | <input type="checkbox"/> Texas Hold'em Dealer |

ENTER FULL CURRENT NAME:

_____	_____	_____	_____
Last Name	First Name	Middle Initial	Suffix (e.g., Jr., Sr.)

ENTER ALL OTHER NAMES USED IN THE PAST (including, but not limited to, maiden name, former married names, alternative spellings):

1. _____
2. _____
3. _____
4. _____

AUTHORIZATION TO RELEASE INFORMATION

As an applicant, I authorize release of any and all information that you have concerning me, including **CRIMINAL HISTORY RECORD INFORMATION** and other information of a confidential or privileged nature. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____ **Date:** _____

Phone: Home _____ Work _____

MAIL THE RESULTS OF MY CRIMINAL HISTORY REQUEST TO:

Division of Professional Regulations
861 Silver Lake Boulevard, Suite 203
Dover DE 19904
SLC D420A

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.



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VERIFICATION OF PHYSICIAN ASSISTANT LICENSE

Send a separate form to *each* jurisdiction other than Delaware where you have ever held a license to practice as a Physician Assistant.

Licensing Authority: _____		Applicant Name: _____	
Address: _____		Home Address: _____	
City/State/Zip: _____		City/State/Zip: _____	
This section is to be completed by applicant.	Last Name: _____ First: _____ Middle: _____		
	SSN: _____ DOB: _____		
	Other Name(s) Used: _____		
	License Number(s) in Jurisdiction Named Above: _____		
	I am applying for licensure as a Physician Assistant in the State of Delaware. Before my application can be reviewed, verification of my license in good standing is required. I am authorizing the release of the information requested on this form to be sent to the Delaware Board of Medical Licensure and Discipline.		
Applicant Signature: _____		Date: _____	
This section to be completed by Licensing Authority.	Our records indicate that the applicant named above was licensed in the State/U.S. Territory of _____		
	License Number: _____		
	Issue Date (mm/dd/yyyy): _____ Expiration Date (mm/dd/yyyy): _____		
	Has any discipline activity taken place regarding this licensee? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please enclose a certified copy of the Board Order with this license verification.		
CERTIFICATION AFFIX OFFICIAL SEAL HERE	Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.		
	Printed Name of Official: _____		
	Signature of Official: _____		Date: _____
	Title: _____		
	Phone: _____ Fax: _____		Email: _____

Mail (do not fax) completed, signed and sealed form *directly* to the Board office at the address above.



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VERIFICATION OF PHYSICIAN ASSISTANT EDUCATION

Physician Assistant applicants should send this form to the program from which graduated.

Educational Institution: _____		Applicant Name: _____	
Address: _____		Home Address: _____	
City/State/Zip: _____		City/State/Zip: _____	
This section is to be completed by applicant.	Last Name: _____ First: _____ Middle: _____		
	SSN: _____ Birth Date: _____		
	Other Name(s) Used: _____		
	I am applying for licensure as a Physician Assistant in the State of Delaware. Before my application can be reviewed, verification of my degree or certification is required. I am authorizing the release of the information requested on this form.		
Applicant Signature: _____		Date: _____	
This section to be completed by Institution.	1. Enter the dates the applicant named above was enrolled in your institution: From (mm/dd/yyyy): _____ To (mm/dd/yyyy): _____		
	2. Was the applicant awarded a degree? Yes <input type="checkbox"/> No <input type="checkbox"/>		
	• If <u>yes</u> , enter: Degree Received: _____ Date (mm/dd/yyyy) Degree Conferred: _____		
• If <u>no</u> , attach explanation of reason applicant did not receive a degree.			
AFFIX INSTITUTION OR NOTARY SEAL HERE	I certify that the information above is an accurate account of the applicant's records and is true and correct.		
	Printed Name of Institution Official: _____		
	Signature of Official: _____ Date: _____		
	Title: _____		
	Phone: _____ Fax: _____ Email: _____		

Mail (do not fax) completed, signed and sealed form *directly* to the Board office at the address above.